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Vision designed for you

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WELCOME!

We are thrilled that you have chosen Chesapeake Eye Care & Laser Center for your **Cataract Evaluation**. Our carefully selected team of doctors offers exceptional personalized service and knowledge of the latest advancements in eye care. We strive daily to provide you with the best education, highest quality eye care and greatest customer experience.

This is an exciting time for cataract patients with the numerous advancements in cataract lenses. In preparation for your visit:

Please mail to us the enclosed information before your appointment:

- A Completed Medical History Form (Front & Back sides)
- A Completed Lifestyle Questionnaire

Please be sure to bring the following information to your appointment:

- Your Insurance Card(s)
- Primary Care Physician Referral (if your insurance requires one)

REGARDING REFERRALS:

If you are unsure if your insurance requires a referral, contact your insurance company and they will give you the necessary requirements. When you speak with your insurance company, be sure to tell them you are coming for a Cataract Evaluation. Referrals are the patient's responsibility.

CO-PAYMENTS:

Most insurance companies require patients to pay a co-payment for their visit. Please be prepared to pay this at your visit. We accept cash, personal checks, Visa, MasterCard, and American Express.

LOCATION:

Our office is located in the Sajak Pavilion near the Anne Arundel Medical Center. We have enclosed a map and directions for your convenience.

If you have any questions, please do not hesitate to call us at 410-571-8733. Thank you again for choosing Chesapeake Eye Care & Laser Center. We look forward to serving you and your eye care needs.

Warm Regards,

Chesapeake Eye Care & Laser Center

Enclosures

MEDICAL HISTORY

FIRST NAME _____ M.I. _____ LAST NAME _____
ADDRESS _____
CITY _____ STATE _____ ZIP CODE _____
HOME PH _____ WORK PH _____ EXT _____
CELL PH _____ EMAIL _____
SS# _____ D.O.B. _____ AGE _____ SEX _____
EMERGENCY CONTACT _____ PHONE _____

Are you interested in learning more about decreasing your dependence on glasses/contacts?
 YES NO

Which of the following referred you to Chesapeake Eye Care: (Please be specific. List all sources.)

Friend/Relative/Patient	Newspaper _____	Seminar
Names _____	Mailing _____	_____
_____	Internet/Website _____	Other _____
Physician _____	Event _____	_____
_____	Article _____	_____

PRIMARY INSURANCE INFORMATION

PRIMARY INSURANCE _____
INSURED NAME _____ INSURED'S D.O.B. _____
POLICY NUMBER _____ GROUP NUMBER _____
CO-PAY AMOUNTS _____

SECONDARY INSURANCE INFORMATION

SECONDARY INSURANCE _____
INSURED NAME _____ INSURED'S D.O.B. _____
POLICY NUMBER _____ GROUP NUMBER _____

PATIENT AUTHORIZATION

I authorize Chesapeake Eye Care to apply for benefits on my behalf for services rendered. I request payment from my insurance company to be made directly to the physician. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims. I permit a copy of this authorization to be used in place of the original. I may revoke this authorization at any time in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical service provided, when a statement is rendered. I understand I will be responsible for any collection fees if my account is delinquent and referred to an attorney for collection purposes. Attorney's fees of 15% will be charged in addition to principal balance of the account if referred to an attorney for collection purposes. Delinquent accounts accrue interest at the rate of 1 1/2% per month.

SIGNATURE _____ DATE _____

Patient Name _____

Occupation or hobby _____

Primary Care Physician _____

Computer Use Never Occasional Daily

When was your last eye exam? _____

Do you wear glasses? Yes No

By whom? _____

Do you wear contact lenses? Yes No

PAST MEDICAL HISTORY

1. Have you ever been treated for any medical condition? (e.g. diabetes, high blood pressure, heart attack, stroke) Yes No If yes, explain: _____

2. Have you ever had any eye disease? (e.g. glaucoma, macular degeneration, eye turning in or out) Yes No If yes, explain: _____

3. Have you ever had any surgeries? Yes No If yes, explain: _____

4. Do you take any medications? (Please include any vitamins and aspirin.) Yes No If yes, explain: _____

5. Medication Allergies: _____

REVIEW OF SYSTEMS

Do you currently have any problems with the following:

Chronic fever, unexpected weight loss or gain, fatigue

Yes

No

Ear/nose/throat (e.g. hearing loss, sore throat, sinus)

Yes

No

Heart (e.g. chest pain, irregular heart beat)

Yes

No

Respiratory (e.g. shortness of breath, coughing)

Yes

No

Gastrointestinal (e.g. heartburn, diarrhea, vomiting, stomach pain)

Yes

No

Urinary (e.g. pain or discomfort, blood in urine)

Yes

No

Skin conditions (e.g. rash, excessive dryness)

Yes

No

Musculoskeletal (e.g. swollen joints, joint pain)

Yes

No

Neurological (e.g. numbness, weakness, headache, paralysis)

Yes

No

Psychiatric (e.g. depression, anxiety)

Yes

No

Endocrine (e.g. diabetes, thyroid)

Yes

No

Blood Lymph (e.g. high cholesterol, anemia)

Yes

No

FAMILY AND SOCIAL HISTORY

Do any eye or medical diseases run in your family? (e.g. diabetes, high blood pressure, cancer, glaucoma, macular degeneration) Yes No If yes, explain: _____

Do you smoke? Yes No

Do you drink alcohol? Yes No

PLEASE CIRCLE REASON FOR YOUR VISIT TODAY:

Routine

Surgery

Glasses/Contact Lenses

Medical Problem

Patient/Parent Signature: _____

Reviewed By: _____ Date: _____ No Changes Updated _____

LIFESTYLE QUESTIONNAIRE

for

Cataract Patients

Patient Name: _____

Date: _____

This check list will assist us in providing the treatment best suited for your visual needs if it is determined that cataract surgery is appropriate for you. It is important that you understand that many patients still need to wear glasses for some activities after surgery; however, due to recent technological advances, we are now able to offer the possibility for you to be potentially free from glasses. Please fill this form out completely and return it to us. If you have any questions, please let us know and we will be happy to assist you.

**Are you interested in seeing well at distance without glasses after surgery?*

____ I prefer no distance glasses.

____ Not important to me. I wouldn't mind wearing distance glasses.

**Are you interested in seeing well at near without glasses after surgery?*

____ I prefer no reading glasses.

____ Not important to me. I wouldn't mind wearing reading glasses.

ZONE 1

Reading

Sewing

Applying Make-up

Working Crossword Puzzles

ZONE 2

Shaving

Emailing

Cooking

Reading Labels on Shelf

ZONE 3

Watching TV

Driving

Watching Movies

Golfing

**Which "Zone of Vision" is most important to you? Please choose only one of the following three options:*

____ Zone 1

____ Zone 2

____ Zone 3

**If you had to wear glasses after surgery for one zone, for which zone would you be most willing to use glasses?*

____ Zone 1

____ Zone 2

____ Zone 3

How important would it be for you to be free from glasses for your daily activities?

____ Very Important

____ Moderately Important

____ Not Important

Please place an "X" on the following scale to describe your personality as best as you can:

Easy Going | _____ | Perfectionist

Patient Signature: _____

Chesapeake Eye Care & Laser Center
Sajak Pavilion
2002 Medical Parkway, Suite 320
410.571.8733

DIRECTIONS TO ANNAPOLIS OFFICE

Our office is located in the Sajak Pavilion.

FROM THE EAST:

- Take Route 50 West to Exit 23A and follow signs to the right for Jennifer Road.
- Get in left turn lane. Turn left at light onto Jennifer Road.
- Turn right onto Medical Parkway.
- Turn left at the next traffic light into the parking garage entrance. *

FROM THE WEST:

- Take Route 50 East to Exit 23 for Parole/Route 450.
- Bear right onto West Street and stay in right lane.
- Make a right at the first traffic light onto Jennifer Road.
- Make a left at the fourth traffic light onto Medical Parkway.
- Turn left at the next traffic light into the parking garage entrance. *

FROM THE SOUTH:

- Take Route 2 North.
- Cross across West Street and Route 2 will connect directly to Medical Parkway.
- Go straight through the light on Jennifer Rd.
- Turn left at the next traffic light into the parking garage entrance. *

FROM THE NORTH:

- Take I-97 to Route 50 East to Exit 23 for Parole.
 - Bear right onto West Street and stay in right lane.
 - Make a right at the first traffic light onto Jennifer Road.
 - Make a left at the fourth traffic light onto Medical Parkway.
 - Turn left at the next traffic light into the parking garage entrance. *
- Once in parking garage, park on the 3rd floor and enter through the 3rd floor garage/building access doors.
Our office is straight ahead. Parking is free.

